

PREP JUL 11 1945

Registration District No. 42

Primary Registration District No. 1501

Registrar's No. 712

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Josephs Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
(Specify whether
In this community about 30 years
years, months or days)

3. (a) PRINT FULL NAME John Lawrence Waviner

3. (b) If veteran, name war unknown
3. (c) Social Security No. unknown

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced unknown

6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased August 8 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 10 20 hr. min.

9. Birthplace Lenkowice Poland 4
(City, town, or county) (State or foreign country)

10. Usual occupation Fireman

11. Industry or business BOX. Quarters Rosecran Field

12. Name Ignac Wawefyniec

13. Birthplace unknown Poland 4
(City, town, or county) (State or foreign country)

14. Maiden name Unknown,

15. Birthplace Unknown, Poland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Louise Pahler, Pub. Adm.

(b) Address St. Joseph, Mo.

17. (a) burial (b) Date thereof 7/5/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet

18. (a) Signature of funeral director Heaton Bittole & Bowman

(b) Address 319 South 10th Street

19. (a) 7/5/45 (b) Telen J. Peck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan 11
(c) City or town St. Joseph 1
(If outside city or town limits, write "RURAL")
(d) Street No. 315 Dakota 7
(If rural, give location)
(e) Citizen of foreign country? no 0 (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28/ 29th
year 1945 hour 10 minute 40 P. M.

21. I hereby certify that I attended the deceased from June 28th 45 to June 29th 45
that I last saw him alive on June 29th, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 2 days

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy

22. If death was due to external causes, fill in the following: none

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) While at work? (e) Means of injury

3. Signature W. M. Toothaker or other
Address Social Welfare Board Date signed 7/2/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

1377

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Frank A. [Signature]*

Licensed Embalmer No..... *1710*

P. O. Address..... *24 [Signature]*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.